

Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: hospital inpatient and outpatient services

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MECIPAC

Summary of payment adequacy

- Access to care is good
- Access to capital is strong
- Quality is improving
- Medicare margins 2014
 - Aggregate margin: -5.8%
 - Marginal profit: +10%
 - Efficient provider: + 1%
 - Projected 2016 aggregate margin: -9%
 - Marginal revenue expected to continue to be higher than marginal cost in 2016



Medicare payments for Medicaid and uncompensated care

- Medicare support for hospitals with high DSH shares, primarily meaning high Medicaid shares*
 - \$3.3 billion in traditional DSH (an add-on to Medicare payment rates based on Medicaid and SSI shares)
 - \$6.4 billion in "uncompensated care" payments. Medicare currently uses
 Medicaid inpatient days and Medicare SSI days as a proxy for
 uncompensated care.
 - \$1.2 billion in Medicare payments above 340B drug acquisition costs
 - \$1.1 billion in "bad debt" payments for dual-eligible beneficiaries in cases where Medicaid declines to pay their hospital coinsurance
- No payments are directly tied to uncompensated care

^{*} DSH days include Medicaid days plus days of Medicare patients on supplemental security income (SSI). Medicaid days represent 85% of the total.



Problems with Medicare subsidizing Medicaid

- The Medicaid program has supplemental payments to pay for Medicaid "shortfalls." Medicare payments for the same shortfalls are duplicative
- If Medicare pays for Medicaid shortfalls, it encourages states to reduce Medicaid rates
- Medicaid "shortfalls" may be due to low payment rates or due to high costs
- At some hospitals there may be no Medicaid shortfall after supplemental payments are considered



Many DSH and 340B hospitals have belowaverage levels of uncompensated care

Category of hospital	Criteria	Share of PPS hospitals	Median share of uncompensated care	Share with below the median level of uncompensated care (<3.6%)
DSH	15% DSH percentage*	80%	3.8%	46%
340B	High DSH* & non- profit/government	35%	4.3	40
All hospitals	All	100	3.6	50

^{*}The DSH percentage is the share of days that are Medicaid plus the share of Medicare patient days that are for patients on SSI. To be a 340B PPS hospital the DSH percentage must meet certain thresholds.

Note: Computed for hospitals with S-10 cost report information. Critical Access Hospitals are excluded. Source: MedPAC analysis of Medicare claims and HRSA file on hospital 340B participation, 2014



Share the 340B discounts with beneficiaries and hospitals providing uncompensated care

- Issue: 340B hospitals' acquisition costs for Part B drugs are much lower than Medicare rates (OIG estimate: discount was 34% of ASP)
- Change: Allow beneficiaries and hospitals providing the most uncompensated care to share in the savings
 - Reduce Medicare rates by 10% of ASP (lowers cost sharing by 10%)
 - Redistribute program savings to the hospitals providing the most uncompensated care
- The 340B program and the mandated discounts from pharmaceutical companies would not change



Using the S-10 to distribute the Medicarefunded uncompensated care pool dollars

- \$6.4 billion in uncompensated care payments in 2016
- CMS uses Medicaid days as the primary proxy for uncompensated care costs*
- Data from hospitals' cost reports (worksheet S-10)
 - S-10 directly measures uncompensated care costs
 - A better indicator of uncompensated care (charity care and bad debts) than the current proxy
 - Using the S-10 would increase payments to public hospitals

*In 2016, a fixed payment of \$174 per day is paid to DSH hospitals for each Medicaid day and each Medicare-SSI patient day. Medicaid days represent 85 percent of Medicare funded "uncompensated care" payments, and Medicare-SSI days represent 15 percent.



Phasing in the use of the S-10

- Hospitals report their uncompensated care costs on worksheet S-10 of their cost report
- We have shown it is a closer match to audited uncompensated care data than the Medicaid proxy
- However, the data are not perfect. There can be errors in reporting charity care charges and bad debts.
 - CMS should be auditing aberrant data
 - CMS should audit the hospitals reporting the largest amounts of uncompensated care
- The three-year phase in will provide an incentive for improved reporting and auditing of the data

